Book Preface

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There is a story (or perhaps it is actually a legend?) that when Mallory was asked why he climbed Everest he apparently replied, “Because it is there”. Similarly, many might want to ask why write a book about mistakes made in the practice of clinical neuropsychology? Like the question itself, there is no simple answer. Perhaps one reason would be because the mistakes, similar to the mountain referred to by Mallory, are there, because they exist? Furthermore, most of us have actually made some of these common mistakes. Or perhaps, are still to make them, especially whilst early in our careers?

There are other important reasons to write a book such as this one. All good practitioner psychologists should know that honest acknowledgement of failure is the key to improvement. However, we also know acknowledgement of failure is not especially common, probably because egocentrism makes this a difficult task for humans. A readable account of this literature can be found in Carol Tavris’ charmingly titled *Mistakes were made (but not by me*) (Tavris and Aronson 2008). Nevertheless, recognising why we made the mistake, and doing something about it, is the key to not making the mistake again.

Secondly, mistakes – and the narrative surrounding mistakes – are an excellent teaching tool. Educational materials wrapped around a personalised anecdote are far often more memorable – probably because the telling of a good story is a skill, and a historically crucial vehicle for the transfer and preservation of knowledge between generations. Indeed, before the modern technologies of neuroscience, perhaps a highly valued clinical skill was the ability to write accurate, perceptive case reports (Code et al. 1996)(Code et al. 2003). Luria’s two case study books (Luria 1972)(Luria 1968), for example, remain some of his most influential and cited works.

 Many of these classic cases in neuropsychology continue inform clinical practice – especially for the *disorders*which they represent: Broca’s Tan-tan (or more correctly Leborgne) for aphasia, HM for amnesia, Phineas Gage for self-regulation and  Luria’s Zazetsky for his many visuo-spatial impairments. Thus, while modern neuroscience continues to dazzle, with new gadgets and techniques for data analysis, we are also enthusiastic that the art of the case report should not become extinct. We can still learn much through this neglected skill in clinical neuropsychology. At least in our experience, it is worryingly common to wade through a technical chapter in a book, and yet perhaps remember little of it a week later. But a narrative well told, a message threaded through a personal story, has far more power to resonate for weeks and years. As noted by (Sacks 1987) neuropsychological cases of brain injured patients resemble classical fables and tales, where common -and often unfortunate- human beings become archetypical figures; heroes, victims, martyrs and warriors.

So, case reports have long been championed for the neuropsychological *disorders*which they represent. However, we believe that the case report can also be a vehicle for understanding the *process*by which clinicians explore, and attempt to understand, disorders. For process is the key to the hypothesis-driven detective work that is at the heart of clinical neuropsychology. When should you ask those extra questions about family background when taking a history? When should you not believe the result of a test, and why should that make you choose another one? When should you follow the rules of test administration, and when should you bend them? The case report is an excellent approach to the problem of decisions and mistakes, because it places the reader at the centre of the dilemma.

And now a positive shout-out for pithy phrases: another excellent source of “things that help memory”. There is again something memorable – like a zen koan, or a phrase from Shakespeare – that brings to mind the key elements of a thought or memory. Early on in our careers, one of us (OT) was fortunate (or unfortunate) enough to witness the legendary Kevin Walsh have a minor rant on a topic that is a chapter title in this book: *There is no such thing as a neuropsychological test.* Understanding why the idea of a “neuropsychological test” is logically flawed helps avoid a key pitfall in neuropsychology – though we confess that in our chapter it takes us several paragraphs to capture what Walsh sums up in a phrase of poetic clinical bile.

Thus, with time, we realised that we, and our colleagues, have perhaps learned as much through our *failings*, than our few successes. We would like to posit that in the career of the average clinical neuropsychologist this is more common that we might want to admit.  Perhaps understandably (as we discussed above), nobody tends to talk much about mistakes, or heaven forbid formally present their ‘best’ mistakes at conferences!  But after several decades of involvement in clinical neuropsychology, we were also surprised to see that no one appeared to write about this topic at all – or at very least we have been unable to find such a book. One does discover a few mentions of “pitfalls” in a book chapter or paper, but nothing exclusively devoted to “getting it wrong”.  It is interesting that the idea of systematically looking at cases that fail, or paying attention to common mistakes that occur during a therapeutic process, has been used as a source of insight in other neighboring disciplines, such as psychoanalytic psychotherapy   (Casement 2002)(Reppen and Schulman 2001)(Goldberg 2012)

Yet with the benefit of hindsight it seems seem clear to us that these common “mistakes” are at least to some degree possibly developmental in nature, and in an unexpected way almost entirely helpful when reflected on, and corrected, during supervision. These common errors of reasoning about are a central part of the process of experientially developing clinical reasoning skills. In the words of the ever-pithy Kevin Walsh “Neuropsychology is a body-contact sport” (Walsh, 1985, p.). However, it may take years to personally make contact with all of these mistakes, and we felt that practicing clinical neuropsychologists as well as those still in training might benefit from some assistance on this journey.

 We hope that this book helps on your journey of developing clinical reasoning skills in neuropsychology. Here we offer 15 short chapters of anecdotes and pithy phrases, pearls of wisdom scattered throughout the case examples used to illustrate the points we make. The cases are amalgams or adaptations of situations and challenges we have either directly, or indirectly through colleagues’ sharing of experiences, encountered. Each chapter is structured according to what we have termed “SEER”. “SEER” stands for Situation, Example, Error, and Reflection. Ironically, a “seer” is a person who can see into the future. If only it were that easy to develop clinical reason skills during the early stages of a clinical neuropsychologist’s career… We would especially like to thank the patients which whom we have had the privilege of spending time, colleagues we have worked with, students keeping us on our toes, and the clinician-teachers from whom we learned so much over the course of many years.

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